DOCUMENT RESUME

ED 292 049 CG 020 656

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TITLE Broverman Revisited: Clinicians' Sex Role Stereotyping in the 1980s.
PUB DATE Aug 87
NOTE 29p.; Paper presented at the Annual Convention of the American Psychological Association (95th, New York, NY, August 28-September 1, 1987).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adults; *Androgyny; Health Personnel; Mental Health; Role Perception; Self Evaluation (Individuals); *Sex Bias; Sex Differences; *Sex Role; *Sex Stereotypes

ABSTRACT

In 1970, Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel administered a Stereotype Questionnaire to 79 male and female clinically trained psychologists, psychiatrists, and social workers. The study concluded that sex bias was demonstrated in that clinicians' trait ascriptions given to the mentally healthy adult person did not differ significantly from traits ascribed to the mentally healthy adult male, but did differ significantly from traits ascribed to the mentally healthy adult female. A study was conducted as a modified replication of the Broverman et al. work using the short form of the Bem Sex Role Inventory (BSRI). Additionally, mental health clinicians' (N=106) personal sex role orientations were compared with their sex role ratings of the mentally healthy person, woman, and man. Sex role ascriptions were found to be a function of rater gender, BSRI scale, and the rated target. The mentally healthy person and woman were rated as androgynous. The mentally healthy man was rated as masculine. In general, clinicians were found to rate theoretical targets with the same sex role orientation as they rated themselves. (Author/NB)

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Broverman revisited: Clinicians' sex role stereotyping in the 1980s

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Presented at the annual convention of the American Psychological Association, New York, NY: August, 1987.

Running head: BROVERMAN REVISITED

ABSTRACT

This study is a modified replication of the Broverman et al. (1970) work using the short form of the Bem Sex Role Inventory (BSRI; Bem, 1981). Additionally, clinicians' personal sex role orientations were compared with their sex role ratings of the mentally healthy person, woman, and man. Sex role ascriptions were found to be a function of rater gender, BSRI scale, and the rated target. The mentally healthy person and woman were rated as androgynous. The mentally healthy man was rated as masculine. In general, clinicians' were found to rate theoretical targets with the same sex role orientation as they rated themselves.

Broverman revisited: Clinicians' sex role stereotyping in the 1980s

In the last 17 years psychotherapists have been criticized for perpetuating societal sex role inequalities within treatment settings (Al-Issa, 1980; Brodsky, 1980; Chesler, 1972). Psychotherapy has been described as an institution functioning to promote social harmony by advocating adjustment and conformity to sex-typed societal standards (Sherman, Koufacos, & Kenworthy, 1978). Essentially, mental health practitioners have been characterized as adhering to a statistical conception of normality and health whereby what constitutes the group average on a descriptive level--the norm--becomes defined as what is normal and healthy on a prescriptive level.

The most influential and often-cited study in the area of sex role stereotypes held by clinicians is that of Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel (1970). The Broverman group (1970) administered a Stereotype Questionnaire to 79 male and female clinically trained psychologists, psychiatrists, and social workers. These subjects indicated which pole of 38 bipolar sex role stereotypic items was most characteristic of the mature, healthy, socially-competent adult person, female, or male. Assuming ratings of the mentally healthy adult person to be the ultimate standard of mental health, ratings of the

mentally healthy man and woman were analyzed to determine their proportional agreement to the item poles most often designated as healthy for the mentally healthy adult person. The Broverman group (1970) concluded that sex bias was demonstrated in that clinicians' trait ascriptions given to the mentally healthy adult person did not differ significantly from traits ascribed to the mentally healthy adult man, but did differ significantly from traits ascribed to the mentally healthy adult woman. The forced choice dichotomous scoring methodology did not allow the Broverman team to assess the strength of these trait ascriptions across mentally healthy adult person, woman, and man rating conditions.

It is possible that these results may have, in part, been an artifact of the instrument used. Of the 38 stereotypical items used in the data analysis, 71% were designated as socially valued for males (the masculine pole was more often seen as desirable) and 29% were labeled socially valued for females (with the feminine pole more often rated as desirable) (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968). Broverman et al. (1970) found a strong positive correlation between social desirability and mental health ratings which has also been found in other research (Nidorf, 1966; Phillips & Gilroy, 1985). One would expect greater consensus in the rating of a mentally healthy

adult man on dichotomous male-valued traits, and the rating of a mentally healthy adult woman on dichotomous female-valued traits, than in the ratings of the mentally healthy adult man and woman on traits considered less stereotypically applicable. Since there were more male-valued items on the questionnaire, it should not be surprising that there was less rater consensus in assessing the appropriate attributes of the mentally healthy adult woman. Also, the male-valued traits contained a significant amount of content overlap, whereas the female-valued items contained little content redundancy. Item redundancy operates to inhibit rating variability. All these points taken together, one would expect a higher consensus and less rating variability when selecting representative poles of dichotomous traits for mentally healthy adult male ratings than when selecting such poles for mentally healthy adult female ratings.

Content imbalance and item redundancy on the Stereotype Questionnaire reduce confidence in the Broverman et al. (1970) findings. The bipolar nature of the Stereotype Questionnaire has led to other problems. Masculine and feminine sex role descriptions are now considered to be orthogonal rather than bipolar opposites (e.g. Bem, 1974; Constantinople, 1973; Spence, Helmreich, & Stapp, 1975). Using bipolar dimensions has also led reviewers and researchers to make errors in logical reversal such that the

pole opposite the empirically derived socially desirable or mentally healthy pole is assumed to be undesirable or unhealthy. All too often, this has contributed to the Broverman et al. (1970) results being interpreted in terms of categorical sex bias in trait ascription rather than as indicating relative differences in rating consensus.

A number of subsequent investigations have been published that fundamentally adhere to the Broverman et al. (1970) paradigm using practicing American clinicians as subjects (Aslin, 1977; Delk & Ryan, 1975, 1977; Fabrikant, 1974; Kabacoff, Marwit, & Orlofsky, 1985; Marwit, 1981; O'Malley & Richardson, 1985; Phillips & Gilroy, 1985; Swenson & Ragucci, 1984). Aslin (1977), Delk and Ryan (1975, 1977), O'Malley and Richardson (1985), and Phillips and Gilroy (1985) all utilized a modified version of the Stereotype Questionnaire used by Broverman et al. (1970). Fabrikant (1974) employed an adjective checklist derived from this instrument. All of these studies are open to the same criticisms leveled against the Broverman et al. (1970) study concerning item content imbalance and redundancy and trait bipolarity.

Constantinople's (1973) review of masculinity-femininity assessment challenged the idea that masculinity and femininity are extreme opposite ends of a unidimensional bipolar continuum. The **Bem Sex Role Inventory** (BSRI; Bem,

1974) was developed to enable people to endorse high levels of both masculinity and femininity (the current operational definition of androgyny) in accordance with Bem's position that masculinity and femininity are two socially valued independent dimensions. A short form of the BSRI was developed in response to psychometric criticism of the original BSRI (Pedhazur & Tetenbaum, 1979) and is psychometrically superior (Bem, 1979, 1981; Goldsmith & Ekhardt, 1984).

Marwit (1981) was the first to replicate the Broverman et al. (1970) study without using an assessment instrument depicting masculinity and femininity as bipolar opposites. He employed the original BSRI (Bem, 1974) but found that all significant effects disappeared when he reanalyzed his data omitting two BSRI items that were excluded from the short form of the BSRI.

Swenson and Ragucci (1984) also did a replication using the original BSRI and the difference/median split method of sex role categorization described by Bem (1977). A reanalysis of their data utilizing the median split procedure more recently advocated by Bem (1981) will demonstrate that clinicians rated the mentally healthy person as undifferentiated, the mentally healthy man as masculine, and the mentally healthy woman as feminine. These results are similar to those found by O'Malley and Richardson (1985).

Kabacoff et al. (1985) performed the only Broverman et al. (1970) style investigation using the preferred short BSRI. They found that clinicians with more liberal attitudes toward women did not rate the mature, socially competent, healthy man and woman differently. Clinicians with relatively more traditional attitudes provided similar masculinity ratings across the two instructional sets but attributed significantly more feminine traits to the mature, socially competent, healthy woman than man.

The present study is a modified replication and extension of the Broverman et al. (1970) investigation using the short BSRI. Clinicians were asked to rate themselves as well as their conception of the mentally healthy person, woman, and man in order to assess sex role stereotyping as a function of therapist sex role orientation.

Method

Participants

Participants were 106 mental health practitioners (38 male and 68 female) from the Midwest. The majority of the sample was obtained from volunteers attending either a statewide psychological association convention (29%) or a conference for social workers (65%). The remainder of the participants (6%) were contacted through a community mental health center. The mean age of respondents was 41 years with a range from 22 to 65 years. Roughly one-third of the sample

(n = 33) held doctoral degrees, 60% held masters' degrees (n = 63), and 10 people held bachelors degrees (9.5%). Participants had been conducting therapy with clients for an average of 12 years with a range from .25 to 40 years of professional practice.

Instrumentation

Bem Sex Role Inventory - Short Form (BSRI). The short form of the BSRI (Bem, 1981) is a self-administered, paper and pencil measure. A 7-point Likert scale is used to rate an identified referent on 30 personality trait descriptors. Ten of the trait descriptors are comprised of masculine-stereotyped traits, 10 of feminine-stereotyped traits, and 10 items serve as filler or neutral items (please refer to Bem, 1981, for detailed scoring procedures). Bem (1981) recommended that BSRI ratings can be classified into one of four sex role categories (androgynous, feminine, masculine, or undifferentiated) based on median split categorizations of the Feminine and Masculine scale scores. Participants' Masculine scale ratings are compared to the median Masculine scale ratings from the entire relevant participant pool, and their Feminine scale ratings are compared to the median Feminine scale ratings from the same participant pool. Any rating above the sample medians on both the Masculine and Feminine scales is classified as "androgynous." Any rating below the sample medians on both of these scales is

classified as "undifferentiated." A rating above the median on the Feminine scale and below the median on the Masculine scale is considered "feminine." A rating above the median on the Masculine scale and below the median on the Feminine scale is considered "masculine." The short BSRI has been found to be psychometrically superior to the original form (Bem, 1974) with higher inter-item correlations and greater internal consistency (alphas ranging from .84 to .87) (Bem, 1981; Goldsmith & Ekhardt, 1984). Bem (1981) also reports support for the construct validity and test-retest reliability of the short form BSRI.

Questionnaire. A questionnaire was included to determine the demographic characteristics of the sample. Respondents were asked to indicate their gender, age, academic degree, and number of years in clinical practice. In addition, they were asked to choose which one theoretical orientation out of eight provided alternatives most closely approximated their own approach.

Procedure

Mental health professionals attending either of the two professional meetings were asked to volunteer to confidentially fill out a questionnaire packet containing a cover sheet (requesting participation and presenting instructions on how to complete the ratings), 4 copies of the short form BSRI, and a questionnaire collecting basic

demographic and descriptive information about the participant. The purpose of the study was not revealed and the rating sheets were not identified as copies of the short BSRI. Either the first or last (fourth) BSRI rating sheet contained the instructions for the participant to "Describe Yourself." Counterbalanced across the remaining 3 BSRI rating sheets were instructions to: "Describe the Mentally Healthy Person," "Describe the Mentally Healthy Woman," and "Describe the Mentally Healthy Man." The top of each rating sheet also contained the rating scale to be used along with the verbal anchors describing each of the 7 rating points (e.g., 1 = never or almost never true; 4 = occasionally true; and 7 = always or almost always true). Participants returned their packets anonymously to a clearly marked return box after they had taken all the time they needed to complete the questionnaires. The six community mental health center therapists who received questionnaire packets from a fellow employee who had attended one of the professional meetings returned their packets anonymously in self-addressed, stamped envelopes supplied by the researcher.

Results

A 2 (rater gender) x 4 (instruction set: ratings of self, mentally healthy person, woman, and man) x 2 (BSRI scale: Masculine and Feminine) repeated measures MANOVA revealed a significant third-order interaction ($F(3, 102)$ =

3.68, $p < .05$). [See Figure 1.] Two-tailed protected t-

Insert Figure 1 about here

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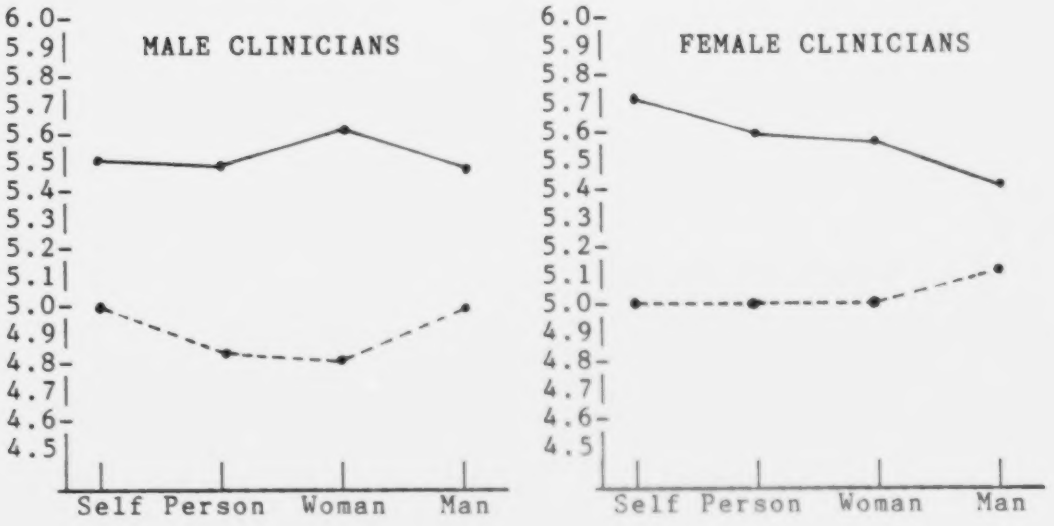
tests were performed to assess differential levels of sex role attribution as a function of instruction set. Results indicated that male therapists rated themselves significantly higher on the Masculine scale than they rated the mentally healthy person ($t(312) = 2.10$, $p < .05$) and the mentally healthy woman ($t(312) = 2.35$, $p < .05$). They also rated the mentally healthy woman significantly higher on the Feminine scale than they rated the mentally healthy man ($t(312) = 2.00$, $p < .05$). Female clinicians rated themselves significantly higher on the Feminine scale than they rated the mentally healthy woman ($t(312) = 2.37$, $p < .05$) and the mentally healthy man ($t(312) = 4.85$, $p < .05$). They also rated the mentally healthy person significantly higher on the Feminine scale than they rated the mentally healthy man ($t(312) = 2.18$, $p < .05$). Finally, female clinicians rated the mentally healthy woman significantly higher on the Feminine scale than the mentally healthy man ($t(312) = 2.48$, $p < .05$) and mentally healthy man significantly higher on the Masculine scale than the mentally healthy woman ($t(312) = 2.22$, $p < .05$).

Figure 1. Mean ratings by male and female clinicians of themselves, the mentally healthy person, the mentally healthy woman, and the mentally healthy man on the masculine (broken line) and feminine (solid line) scales of the short BSRI.



In further explicating the significant gender x instruction set x BSRI scale interaction two-tailed protected *t*-tests were also performed to assess levels of sex role attribution as a function of rater gender. Female clinicians rated themselves significantly higher on the Feminine scale than male clinicians rated themselves ($t(312) = 3.14$, $p < .05$). Likewise, female clinicians rated the mentally healthy person, woman, and man as significantly higher on the Masculine scale than did male clinicians ($t(312) = 2.93$; 2.87; 2.56, $p < .05$, respectively).

Subsidiary analyses were performed in order to assess the influence of clinician age, academic degree, theoretical orientation, and number of years in clinical practice on clinicians' self-ratings and ratings of the mentally healthy person, woman, and man. Three separate 2 (rater gender) x 4 (instruction set) x 2 (BSRI scale) repeated measures MANOVAs were performed using age, academic degree, or years in practice as a covariate. The only significant correlate was academic degree ($F(1, 103) = 4.31$, $p < .05$). Incorporating academic degree as a between subjects factor in place of rater gender, the resulting 3 (academic degree: doctoral, masters, or bachelors) x 4 (instruction set) x 2 (BSRI scale) repeated measures MANOVA yielded a significant main effect for academic degree ($F(2, 103) = 3.44$, $p < .05$) as well as a significant instruction set x BSRI scale interaction ($F(3,$

101) = 7.07, $p < .01$). Results indicated that therapists with more advanced degrees tended to use lower ratings on both BSRI scales.

Median splits were used to categorize ratings by male and female clinicians into androgynous, feminine, masculine, and undifferentiated sex role groupings. Bem (1981) recommended that researchers calculate median splits based on either sample medians derived from the particular ratings under study, or from the normative medians she obtained from her 1978 sample of college undergraduates. Because categorization by median split is contingent on the arbitrary composition of the participant sample, median splits were performed using both sample-derived medians and Bem's 1978 normative medians. Results found to be consistent across current sample median and normative median categorizations may be interpreted as providing evidence for the generalizability of the present study's findings.

For analyses using the present study's medians, self-ratings were divided by medians derived only from self-rating scores since there is evidence that rating a theoretical referent appears to be different from rating oneself (Belcher, Algina, & Crocker, 1985; Der-Karabetian & Smith, 1977; Myers & Gonda, 1982; Pedhazur & Tetenbaum, 1979). The sample median Masculine and Feminine scale scores from self-ratings were 5.0 and 5.6, respectively. The sample median

Masculine and Feminine scale scores from ratings of the mentally healthy person, woman, and man were 4.9 and 5.5, respectively. For analyses using normative medians, the Masculine scale median was 4.8 and the Feminine scale normative median was 5.5. Note that these medians were similar to those obtained in the present study.

Separate 3 (instruction set) x 2 (BSRI scale) x 2 (rater gender) x 4 (rater sex role orientation: androgynous, feminine, masculine, and undifferentiated) repeated measures MANOVAs were performed using current sample and 1978 normative medians. There were significant BSRI scale x instruction set interactions when using the current study's medians ($F(2,80) = 8.52$, $p < .001$ and the normative medians ($F(2,91) = 9.67$, $p < .001$). Overall, clinicians rated the mentally healthy person and woman as androgynous and the mentally healthy man as masculine.

In general, it was evident that clinicians tended to rate theoretical others (mentally healthy person, woman, and man) with the same sex role orientation as they rated themselves. Separate repeated measures MANOVAs revealed 2 (rater gender) x 4 (rater sex role) x 2 (BSRI scale) 3-way interactions for current sample ($F(3,81) = 3.6$, $p < .05$) and normative medians ($F(3,92) = 3.65$, $p < .05$). Significant interactions were also found between sex role category of rater and BSRI scale for both sets of medians. These

findings permitted consideration of clinicians' ratings of theoretical others for separate and combined rater genders. For current sample medians, the combined genders consistently rated the theoretical targets with their own BSRI type.

More specifically, using current sample or normative median splits, female and male clinicians whose BSRI type was androgynous rated the mentally healthy person, woman, and man as androgynous. Using either set of medians, female and male clinicians whose BSRI type was masculine rated the targets as masculine. For both the current sample and normative medians, combined female and male undifferentiated clinicians rated the targets as undifferentiated. For normative medians when genders were considered separately, both female and male BSRI-undifferentiated therapists rated the targets as undifferentiated. However, when using the current sample medians, undifferentiated female therapists rated the targets as undifferentiated while undifferentiated male therapists rated the targets as feminine.

Using the current sample medians, only female BSRI-feminine therapists and all feminine therapists combined rated the targets as feminine. [It should be noted that there were only four male BSRI-feminine therapists and, therefore, their mean ratings and subsequent categorizations should be viewed cautiously.] With the current sample medians the female BSRI-feminine therapists rated the targets

as androgynous. Both female and male BSRI-feminine clinicians rated the targets as androgynous when normative medians were used.

Discussion

The present study was undertaken to assess the sex role ascriptions held by clinicians and to test whether and in what way clinician sex role orientation was associated with sex-typed trait ascriptions given to the mentally healthy person, woman, and man. Sex role categorization was calculated using the median split procedure employing current sample medians and Bem's (1981) normative medians to maximize generalizability of study findings. Prior to sex role categorization procedures, a repeated measures MANOVA was performed to analyze clinicians' mean self-ratings and ratings of the mentally healthy person, woman, and man on the short form of the Bem Sex Role Inventory. Sex role ascriptions were found to be a function of rater gender, BSRI scale, and rated target.

Female clinicians typically rated targets with higher scores than did males, especially on the BSRI Masculine scale. Also, all mean Feminine scale ratings were higher than mean Masculine scale ratings for each particular rated target. Both male and female clinicians rated the mentally healthy woman as significantly more feminine than the mentally healthy man. Female raters perceived the mentally

healthy man as significantly more masculine than the mentally healthy woman. Ratings of the mentally healthy man were more often significantly different from other target ratings than any other single rated target.

Of particular interest is the fact that male therapists rated themselves as the most masculine target while female therapists rated themselves as the most feminine target. Rather than conclude that therapists consistently consider themselves to be more sex role stereotyped than is healthy, it may be useful to reconceptualize the rating of theoretical others as involving a kind of averaging. Perhaps ratings of theoretical targets combine the characteristics of a number of people. Therefore, the "mentally healthy woman" may represent an averaging of the characteristics of mentally healthy women with whom the rater is familiar. Similarly the "mentally healthy person" may represent an averaging of the rater's conceptions of mentally healthy women and men. This understanding contrasts with the assumption of Broverman et al. (1970) that ratings of the mentally healthy person represent the singular standard of mental health. Rather than some ultimate standard, research may be accessing an averaging of sex role characteristics.

Keeping the above in mind, an examination of the gender x instruction set x BSRI scale interaction graphed in Figure 1 reveals that male clinicians assigned more differentiating

ratings on the BSRI-Masculine scale and female clinicians assigned more differentiating ratings on the BSRI-Feminine scale. The only differential ratings male clinicians made on the Feminine scale and female clinicians made on the Masculine scale was to rate mentally healthy men and women as significantly different. This kind of differential rating across gender of ratee is often conceptualized as stereotyping (and therefore, detrimental). Yet male clinicians rated themselves as significantly more masculine than the mentally healthy person and woman. Thus, on the Masculine scale, male clinicians rated themselves as most different. Similarly, on the Feminine scale female clinicians rated themselves as significantly more feminine than the mentally healthy man and woman. Are these evidences of self-stereotyping by clinicians? Does the female clinician believe she is more feminine than is healthy for a man or woman? Such would be the conclusions suggested by the Broverman et al. (1970) conceptualization of descriptions of mentally healthy targets as optimal prescriptions for mental health rather than as averaged descriptions of the target population. Perhaps future research in this area will test these assumptions directly.

Analyses of the demographic information considered in this study revealed that only academic degree was found to significantly correlate with target ratings. In fact,

academic degree was found to be more predictive of clinician ratings than was therapist gender. This finding may have important research implications since studies on therapist attitudes often employ heterogeneous clinician groups involving varying proportions of doctoral, masters-level, and bachelors-level mental health practitioners. Inconsistent findings across relevant studies may be a partial function of samples not being equivalent on this variable.

Overall, the clinicians in this investigation rated the mentally healthy person and woman as androgynous and the mentally healthy man as masculine. The mentally healthy person was categorized as androgynous by female clinicians using either current or normative medians. Male clinicians, however, rated the mentally healthy person as undifferentiated or masculine, depending on whether current or normative sample medians were used, respectively. The mentally healthy woman was rated as androgynous by female therapists using either set of medians and by male therapists using normative medians. Male therapists rated the mentally healthy woman as feminine when current medians were employed. Calculated with either set of medians, both female and male clinicians rated the mentally healthy man as masculine.

The finding that female therapists rated themselves as androgynous, and that ratings of the mentally healthy woman by the entire sample of clinicians were primarily androgynous

may indicate that restrictive sex roles for women are not as pervasive among clinicians as has been feared. Exact interpretations of what it means to be rated as androgynous are unclear, however. Currently, persons considered androgynous are those who are rated highly on lists of differentially desirable sex role stereotypic traits. However, as Rowland (1980) suggested, it may be those who are currently categorized as undifferentiated who should be considered the truly androgynous people, since they are not rated highly on either set of these masculine- and feminine-stereotypic traits.

The fact that androgynous, feminine, masculine, and undifferentiated therapists tended to ascribe to theoretical, mentally healthy targets the same sex role with which they described themselves brings up several important issues. It remains unclear whether this tendency may be interpreted as evidence that these clinicians use themselves as the standard of mental health, whether they accommodate to the standard of mental health they ascribe to others, or whether some other process is involved. Furthermore, while the literature is inconsistent in ascribing sex-typed attitudes to clinicians in general, it is of debate as to whether known sex role attitudes tend to play themselves out in therapy (Sherman, 1980; Smith, 1980; Whitely, 1979). There is, however, some evidence that therapists perceive greater improvement in

clients who share their social values (Landfield & Nawes, 1964; Rosenthal, 1955; Welkowitz et al., 1967). What remains of question is the salience and impact of clinicians' sex role orientation values as well as their breadth of tolerance (or one could hope, even "celebration") of diversity.

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